Glossary

Washington State, DSHS HRSA

Glossary

Numbers

837: The HIPAA compliant Health Care Claims Transaction used by HRSA for electronic claim submission.

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1099: A federally mandated tax form sent annually to the IRS and to most providers that receive payments from DSHS. There are no deductions from payments to 1099 providers.

A

A-19: A claim form submitted to DSHS by providers of social services.

Access: To retrieve information for purposes of inquiry or update. See also **Electronic Access**.

Access to Baby and Child Dentistry (ABCD): A program that focuses on preventive and restorative dental care for Medicaid-eligible children from birth to age six, with parents encouraged to enroll children by age one.

Accounts Payable (AP or A/P): A record of the state's legal obligation to pay a vendor or provider.

Accounts Receivable (AR or A/R): A record of payments due to the state from providers, vendors, or clients.

Ad Hoc Report: A report generated on an as-needed basis (e.g., a legislative inquiry).

Adjudication: The processing of a transaction (claim) resulting in either a Pay, Deny, or Suspend status.

Adjust: To apply a debit or credit to an account or claim amount or to change.

Adult Family Home (AFH): A family home that contracts with DSHS to provide personal care and room and board for one to six adults unrelated to the person(s) providing the care. AFHs are licensed by ADSA.

Affiliated Computer Services (ACS): A large computer service firm that serves HRSA as a claim processor and fiscal manager.

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Agency: The Director, DSHS and/or the delegate authorized in writing to act on the Director's behalf.

Agency Contracts Database (ACD): A database used to maintain contracts with providers. The MMIS Core Provider Agreements (CPAs) are not included in this database.

Agency Financial Reporting System (AFRS): The state financial system of record that includes general ledger, accounting, accounts payable and payments.

Aging & Disability Services Administration (ADSA): One of the seven administrations of DSHS. ADSA brings together long-term care programs, home care, residential care, boarding homes, adult family homes, and nursing homes that are targeted to elderly people and adults with disabilities.

Agreement or Contract: A formal written document that defines what is expected of the Contractor/Vendor (Apparent Successful Vendor (ASV) until contract is signed) and DSHS. A proposed contract (agreement) is included with this document as Appendix AA – Sample Contract (Agreement).

Alert: A brief message or reminder that an online system displays to its users.

Algorithm: A rule or procedure for solving a particular problem.

Alien Emergency Medical (AEM): A program that pays for emergency medical services to non-citizens.

Ambulatory Payment Classification (APC): Categories of services and procedures developed for the facility component of ambulatory care. Included services are ambulatory surgery, emergency room and outpatient procedures, and services performed in ancillary clinic settings.

American Dental Association (ADA): A national organization that establishes standard codes for dental procedures.

American Sign Language (ASL): A complex visual-spatial language used by the deaf community in the United States and English-speaking parts of Canada. It is a linguistically complete, natural language and is the native language of many deaf men and women, as well as some hearing children born into deaf families.

American Society of Anesthesiologists (ASA): An organization of anesthesiologists that establishes anesthesia Procedure Codes that DSHS crosswalks to CPT Procedures.

Ancillary Health Services: Health services ordered but not performed by a physician, including but not limited to, laboratory services, radiology services, and physical therapy.

Applicant: An individual who has applied for assistance from DSHS but is not yet an eligible client.

Application Process: The process by which a DSHS applicant becomes a client, including filing and completion of an application form, in-person interviews, and verification of required information.

Application Software: Vendor or a third party's standard application software that is integrated into the MMIS. Enhancements to the Application Software provided by a Vendor or its suppliers will be considered as Application Software.

Apply: To put into operation or effect.

Assign: To designate or mark for a specific purpose.

Assistance Unit (AU): A group of people who apply for or receive assistance together for a program. A household receiving both TANF and Food Stamps will have two AUs, one for each program.

Associate: To bring together or to connect.

Attorney General's Office (AGO): Serves as legal counsel to more than 200 state agencies, boards and commissions, and colleges and universities, as well as to the Legislature and to the Governor. Advises and assists county prosecuting attorneys in the investigation, and if needed, the prosecution of crimes (including criminal prosecution of provider fraud). Issues legal opinions upon the request only of legislators, the heads of state agencies and county prosecuting attorneys.

Audit: In claim processing, an automatic validation procedure that compares data on a claim with historical claim data, for example duplicate checking. Historical claim data can also be defined as information on another line on the same claim. Contrast with **Edit**.

Audit Trail: Supplementary information that enables a reviewer to identify each step of a process and its results.

Authorization (medical services): For medical services administered by DSHS, the process by which a client or provider requests services that are not automatically included in the benefit plan.

Authorization (social services): For social services administered by DSHS, the process by which a case manager or social worker approves services for a client.

Automated Client Eligibility System (ACES): A data processing system designed to support client, financial, and management activities within DSHS. Through this system, staff members enter, update and inquire on data relating to assistance units, clients, other agencies, and providers. The ACES maintains eligibility information for most DSHS programs and interfaces with MMIS.

Automatic/Automatically: Done by a computer without human intervention.

Automatic Maximum Allowable Cost (AMAC): An amount on First Databank's Drug File that can be used in pharmacy claim pricing.

Automatic Voice Response System (AVRS or AVR): A telecommunications system that automatically responds to and records calls from interested parties.

B

BarCode: The computer system used by CSOs and others to track applications for benefits and perform application processing.

Batch Processing: A mode of computer processing in which data in submitted to a system and processed at a later time. Contrast with **On-line Processing**.

Beta Test: A second test of a computer system conducted by an entity other than the system developer.

Bidder: The firm or entity responding to this Request for Proposal (RFP).

Billing Provider: A provider of medical or medically related services or equipment that submits claims for the services or equipment. A billing provider can be the same as the performing or rendering provider or it can be a medical group or billing agent with a different name and identifier.

Buy-In: A premium paid by DSHS to the Social Security Administration on behalf of recipients eligible for Medicare.

C

Callback: A feature of voice response systems in which the system automatically returns standard, pre-recorded messages to callers.

Call Management System (CMS): A telecommunications management system used to track incoming calls and to monitor the number of calls, length of calls, and hold times.

Capitation: Payments to health plans based on the number of covered individuals rather than on the services provided. Also called a "Premium." Contrast with **Fee-for-Service**.

Capture: To bring data into a system.

Case and Management Information System (CAMIS): An in-house mainframe system that tracks children's medical, dental, and EPSDT information for the Children's Administration.

Case Manager: A DSHS worker who is continuously responsible for assigned clients.

Case Management System: A computer system that enables case managers and social workers to manage client services and track client use of facilities and resources.

Certified Average Wholesale Price (CAWP): An amount on First Databank's Drug File that can be used in pharmacy claim pricing.

Centers for Medicare & Medicaid Services (CMS): A federal office under the Secretary of Health and Human Services, responsible for the review/approval of the MMIS Re-Procurement plans and for 90% Federal Funding Participation (FFP).

Chemical Dependency (CD): A general term to describe a physical or psychological reliance on drugs.

Child Profile: Washington State's health promotion and immunization registry system. The health promotion program mails health promotion and educational materials to parents of children birth to six years of age. The immunization registry tracks immunizations for all children in the State of Washington.

Children's Administration (CA): One of the six Administrations of DSHS. CA is committed to the safe and healthy growth and development of children in their homes, in out-of-home placements, and in day care. CA provides a comprehensive range of services to protect children from abuse and neglect, to support families, and to ensure quality care for children.

Children's Administration Management Information System (CAMIS): An in-house system that supports case management activities including eligibility determination and tracking of children's placement, legal, medical, dental, and EPSDT information for the Children's Administration. CAMIS also provides data feeds to SSPS through a nightly batch process for authorizing client services.

Children's Health Insurance Program (CHIP): A program administered by HRSA for the State of Washington. CHIP (also called the State Children's Health Insurance Program or SCHIP) is a program operated by the state, in partnership with the federal government under Title XXI of the Social Security Act. The federal government pays 66.28 percent of CHIP expenditures and the state pays 33.72 percent. Children from families with incomes up to 250 per cent of the Federal Poverty Level are eligible for CHIP. Children covered under CHIP receive their medical services from a managed care plan or from HRSA's fee-for-service program. Families share in the costs of the program by paying monthly premiums and co-payments for some services.

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Claim: A paper or electronic request for payment submitted by a fee-for-service provider.

Claim Form: A pre-printed sheet of paper on which a medical or medically related provider can enter identification and service information and submit for payment. The following claim forms are used by DSHS Administrations: HCFA- (or CMS-) 1500s for physician and practitioner services, UB-92s for inpatient and outpatient institutional services, ADA Forms for dental services. Pharmacy claims are normally submitted with on-line transactions. For non-medical social services, invoices sent by DSHS and returned by providers are equivalent to claims.

Claims Processing Assessment System (CPAS): An annual federal review of claim processing by State Medicaid Agencies.

Claims Processing Functions: Claim edits, audits, and pricing functions normally handled by an automated Claims Processing System.

Clean Claim: A claim that has no defect, impropriety (including a lack of any required substantiating documentation), or particular circumstance requiring special treatment that prevents timely payment.

Client: An eligible person in a program administered by DSHS. Also known as a recipient in the Medicaid environment.

Client Activity and Tracking System (CATS): A system used by the Juvenile Rehabilitation Administration to track juvenile placement, locations, and sentencing.

Client Authorization Services Input System (CASIS): Otherwise known as the SSPS front-end. CASIS is used by case workers for creating an SSPS authorization for client services with an automated electronic form. The application validates client data in the Developmental Disabilities Division (DDD) Common Client Data Base (CCDB), and validates provider and service code data in the SSPS before submitting the authorization to SSPS.

Client Management Information System (CMIS): An in-house DSHS system that tracks client contact information, including caller information and reasons for contact. CMIS subsystems track enrollments, complaints, recoupments, exemptions, and dis-enrollments. CMIS makes use of data extracted from MMIS and IPND.

Client Participation: The amount a client is responsible to pay each month toward the total cost of care they receive each month. It is the amount remaining after subtracting allowable deductions and allocations from available monthly income. (Some states refer to this as a Cost Share.)

Client on Review: A person receiving benefits who is being scrutinized by DSHS because the Agency has reason to believe that he or she is ineligible for services or is using services inappropriately.

CMS-64: A lengthy, federally mandated report (also known as the HCFA-64) produced by state Medicaid agencies such as HRSA. CMS-64 data is the basis for the federal matching funds paid to Medicaid states.

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CMS-1500: A standard claim form (also known as the HCFA-1500) for professional services.

Code Set: A group of standard values for a particular data element. Many code sets, including values of HCPCS Procedure Codes, are mandated by HIPAA.

Coinsurance: The portion of a fee-for-service provider's billed charges that Medicare or another non-Medicaid carrier pays for approved medical expenses.

Collection and Accounts Receivable (CARS): A system maintained by the Office of Financial Recovery for use in recovering overpayments.

Community Alternatives Program (CAP): A Medicaid waiver program that provides options in living arrangements to developmentally disabled clients in need of an Intermediate Care Facility - Mentally Retarded (IFC-MR) level of care.

Community Options Program Entry System (COPES): A Medicaid waiver program that provides a client who has been assessed as in need of nursing facility care the option to remain at home or in an alternate living arrangement.

Community Services Office (CSO): A local office of DSHS that provides cash, medical, and food benefits and services to eligible persons within a designated region.

Comprehensive Assessment Reporting and Evaluation (CARE): An in-house system that determines client eligibility and service payment level for clients in ADSA home and community programs.

Computer Service Request (CSR): A request by system users for system changes or enhancements submitted on a standard form.

Conman: An in-house DSHS system that maintains contracted expenditures and other contract information.

Contact: An interchange between a DSHS worker and a client, provider, or other party. A contact can be in person, by phone, or by letter or e-mail.

Contact Management System: An automated system that tracks a customer's contacts with DSHS representatives.

Coordination of Benefits (COB): The process by which multiple health insurance carriers determine payments for covered services. Also known as Third Party Liability or TPL.

Co-Payment: The amount that a client pays towards the cost of a medical service. DSHS pays the remainder of the cost up to a set maximum rate.

Core MMIS: Defined as the 6 MMIS subcomponents as defined by Part 11 of the CMS State Medicaid Manual (i.e., recipient, provider, claims, reference file, Surveillance and Utilization (SUR), Management and Administrative Report (MAR) subsystems), as well as Managed Care functionality.

Core Provider Agreement (CPA) Form: A standard form used to enroll an eligible provider in order to assign a unique provider identifier.

Correcting Coding Initiative (CCI) Edits: A large set of Procedure Code edits that prevent provider unbundling of Codes that are covered by a single comprehensive Code value.

Correspondence: Written communications with outside parties, frequently communications generated by computer systems.

Cost Avoidance: A form of COB in which a payer such as HRSA refuses to pay a claim because another carrier is primary and refers the claim to the other carrier. Contrast with **Pay and Chase**.

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Create: To make or to produce or bring about by a course of action.

Critical Access Hospital (CAH): A hospital designation/program that was created by the 1997 federal Balanced Budget Act as a safety net device, to ensure that Medicare beneficiaries have access to health care services in rural areas. It allows flexible staffing options relative to community needs, simplifies billing methods and creates incentives to develop local integrated health delivery systems, including acute, primary, emergency, and long-term care.

Cross Administration Team (CAT): A workgroup made up of Administration officials from across DSHS. CAT members are responsible for the coordination of project status and communication of issues relative to system and business requirements for the modern MMIS.

Crosswalk: A list that associates one set of values with another, for example a crosswalk between J Procedure Codes and NDC Drug Codes.

Current Dental Terminology (CDT): A set of dental Procedure Codes created by the American Dental Association. CDT Codes appear within the HCPCS Procedure Code Set.

Current Procedural Terminology (CPT): A set of medical Procedure Codes performed by physicians and other practitioners. CPT Codes are also known as Level 1 HCPCS Codes.

Customer Automated Tracking System (CATS): An in-house system used by the Juvenile Rehabilitation Administration (JRA) that tracks provider and client enrollment and program participation.

D

Data: In a computer system, coded representations of meaningful words, numbers, or pictures. Contrast with **Process**.

Database Management System (DBMS): A sophisticated electronic file structure that optimizes the way in which a system's data is stored and accessed.

Data Warehouse: An integrated collection of computer-based information that is organized to answer strategic, rather than operational, questions.

Day/Calendar Day: Monday through Sunday.

Decision Support System (DSS): Software and databases designed to help people at all levels of an organization make decisions.

Define: To determine or identify the essential qualities of.

Denial: A determination that a client is not eligible for assistance or that information sufficient to establish eligibility is lacking.

Department of Health (DOH): A State of Washington department outside of DSHS that interfaces with DSHS Administrations in a variety of ways, including immunization registration, provider licensing, and vital statistics.

Department of Information Services (DIS): The State department that oversees the procurement and implementation of information systems and infrastructure for all Washington State agencies.

Department of Social and Health Services (DSHS): A State of Washington Department with six administrations that provide medical and social services to 1.3 million children and families each year.

Derive: To deduce

Determine: To decide by choice of alternatives or possibilities.

Developmentally Disabled (DD): A category of severely handicapped clients.

Diagnosis Related Group (DRG): A classification system which categorized hospital patients into clinical coherent and homogenous groups to determine payment.

Disease Management Organization (DMO): An entity that oversees treatment protocols for patients with serious medical conditions.

Disease Management Program: An HRSA program for voluntary case management of clients with serious medical conditions.

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Division of Child Support (DCS): A division within ESA that establishes paternity and collects child support for public assistance and non-assistance clients. DCS also determines if a client is not cooperating with support collection activities.

Division of Developmental Disabilities (DDD): A division within ADSA that is responsible for services to developmentally disabled persons.

Division of Employment and Assistance Programs (DEAP): An ESA Division that coordinates services and payments for health screenings for refugees and GA applicants.

Division of Fraud Investigations (DFI): A division within the DSHS Management Services Administration responsible for detection and investigation of fraudulent activities by providers and clients.

Division of Medical Management (DMM): An HRSA division that performs medical review and quality assurance.

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Documentation: Written and/or graphic material that describes organizational procedures and/or system processes.

Doing Business As (DBA): A name assigned to businesses licensed by the State of Washington, including providers of medical and medically related services.

Drill down: The process of going from high-level information to lower-level information that supports it, for example, drilling down from a claim summary report to detail-level claim data.

Drill up: The process of summarizing lower-level, detailed information into high-level information, for example, drilling up from claims level data to create a claim summary report.

Drug Enforcement Administration (DEA): The federal agency that assigns identification numbers to providers authorized to prescribe controlled drugs.

Drug Manufacturers: Corporations that manufacture prescription and over-the-counter drugs and provide rebates to State Medicaid Agencies for drugs on pharmacy claims.

Drug Rebate: A program in which State Medicaid Agencies apply to drug manufacturers for rebates for portions of payments that they have made for prescription drugs.

Drug Utilization Review (DUR): A feature of point-of-sale (POS) pharmacy claim systems that notifies pharmacists of the potential for adverse drug interactions and other situations in prescribed drugs may be contraindicated.

DSHS Project Director: The person designated by DSHS to be responsible for financial and contractual matters regarding this RFP and resulting Agreement.

DSHS Project Manager: The person designated by DSHS to be responsible for day-to-day management of DSHS resources for the project and monitoring the status of the Vendor's performance under the resulting Agreement.

Durable Medical Equipment (DME): Reusable equipment, such as wheelchairs, required by some patients.

Durable Medical Equipment Region Carrier (DMERC): A Medicare carrier for durable medical equipment.

E

Early and Periodic Screening Diagnosis and Treatment (EPSDT): A federally sponsored program for childhood immunizations, checkups, screenings, and treatments (also called Healthy Kids in Washington State).

Economic Impact Statement (EIS): A report describing the expected financial impact of a proposed activity.

Economic Services Administration (ESA): One of the six administrations of DSHS. ESA provides economic support, employment training, child support, medical services, and other services to help people in need achieve and maintain self-sufficiency.

Edit: An automatic procedure that checks incoming data for completeness, validity, and consistency. In claim processing, edits are validation procedures that involve a single claim rather than historical claim data. Contrast with **Audit**.

Electronic Access: Access to data maintained by a computer system through a terminal, AVRS, IVRS, Web Site, swipe card, or other device.

Electronic Fund Transfer (EFT): A method of transferring funds by means of electronic transactions rather than paper checks or warrants. EFT payments from Medicaid Agencies to providers and health plans are supported by HIPAA Transactions.

Eligibility: Fulfillment of requirements and meeting of qualifications to receive medical and/or social services. ACES performs eligibility determination functions for most DSHS clients. Contrast with **Enrollment**.

Eligibility Verification System (EVS): An electronic system that tells requesting providers whether or not a person is eligible for benefits.

Eliminate: To remove entirely.

Emergency Room (ER): A section of a hospital for patients with serious injuries or medical conditions in need of immediate treatment.

Employer Identification Number (EIN): A federally assigned identification number similar to a Social Security Number but assigned to businesses and other employers rather than individuals.

Employment Security Department (ESD): A State of Washington Department outside of DSHS that HRSA uses to obtain information on provider employees.

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Encounter: A paper form or electronic transaction similar in format to a claim but used for reporting rather than to request payment. In the capitated Medicaid environment, health plans submit encounters to Medicaid Agencies such as HRSA to report on member services. Contrast with **Claim**.

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End State Renal Disease (ESRD): A serious kidney condition that frequently requires dialysis and other very costly treatments.

Enrollee: An individual eligible for medical benefits who participates in a particular program or health plan.

Enrollment: (1) The act of a client's becoming a member of a health plan, either by means of the client's decision or by an automatic process. (2) The act of a medical or medically related provider's applying for participation in the Medicaid Program on either a fee-for-service or capitated basis.

Ensure: To guarantee or make sure of an occurrence

EPIC: A national database of manufacturers' suggested retail prices.

Equipment: Equipment provided by the contractor and DSHS under the terms of the contract awarded as a result of this RFP.

Establish: To institute or bring into existence

Estimated Due Date (EDD): For a pregnant client, a physician's estimate of the date on which the baby will be delivered.

Exception Case Management (ECM): A unit within HRSA that works with exceptional client situations such as health plan disenrollment requests and the Patients Requiring Regulation (PRR) program.

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Exception to Rule (ETR): A category of authorizations for medical services that are not normally covered by HRSA, for example breast reduction surgery for a woman with severe back problems.

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Exception to Rule Database: A database used by HRSA prior authorization staff to generate worksheets and client notification letters and to track program activity for ETR authorizations.

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Executive Administration (EA): The Executive Offices of the DSHS Secretary and Deputy Secretary.

Executive Steering Committee (ESC): The ESC is made up of DSHS executives who oversee the resource management, budget, and status of the MMIS Re-Procurement Project. Monthly ESC meetings are held to communicate the status of the project, deal with high-level issues, and mitigate risk.

Expedited Prior Authorization (EPA): A method of authorization used by HRSA that avoids manual review of authorization requests by analyzing previous authorizations to establish validity criteria for data on incoming claims.

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Extended Database (EDB): An MMIS database of paid claims; used in extracting and reporting claims data rather than in claim adjudication.

Extensible Markup Language (XML): An Internet language that support transmission of formatted data.

Extract: To select and separate

F

Federal Employment System: A system that maintains data on federal employees with which HRSA interfaces for TPL information.

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Federal Medical Assistance Percentage (FMAP): The percentage of state Medicaid expenditures contributed by the federal government. The percentage can differ for different kinds of Medicaid activities.

Federal Poverty Level (FPL): Guidelines developed and updated annually by the federal Department of Health and Human Services (HHS) that are used to establish eligibility criteria for many assistance programs. The FPL specifies income amounts for various household sizes below which people are considered impoverished.

Federal Upper Limit (FUL): Upper limits for drug payment amounts maintained by CMS.

Federally Qualified Health Center (FQHC): A community health center or clinic that provides services to low-income people and meets federal qualifications for receipt of Medicaid payments.

Federal Insurance Contributions Act (FICA): Social Security and Medicare deductions from employee income reported on W-2 Forms. Providers that receive 1099 Forms are responsible for their own FICA contributions.

Federal Unemployment Payroll Surtax (FUDA): Federal contributions to unemployment insurance funds that is deducted from employee income. Providers that receive 1099 Forms are responsible for their own FUDA contributions.

Fee-for-Service (FFS): Payment to providers based on services performed rather than on the number of clients covered. In Washington, the FFS program covers services to elderly and disabled Supplemental Security Income (SSI) clients, clients exempted from Healthy Options or in state administered programs, and Medicaid services not covered by managed care plans. Contrast with **Capitated**.

First Databank: An organization that maintains and distributes up-to-date electronic drug information on a monthly basis. The First Databank Database combines descriptive and pricing data with a selection of advanced clinical support modules.

Fraud Abuse & Detection (FAD): A payment review and audit activity conducted by HRSA's Information Services Division.

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Frequently Asked Questions (FAQ): A common acronym for answers to questions posted on the Internet.

Full Time Equivalent (FTE): A widely used term for measuring the extent of an employer's employment. A full-time employee, or two half-time employees, is considered one FTE.

G

General Assistance (GA): A state-funded program that provides cash and medical benefits.

General Assistance-Unemployable (GA-U): A state-funded GA program that provides cash and medical benefits for persons who are physically and/or mentally incapacitated and unemployable for more than 90 days. GA-U medical care is limited.

Generic Code Number (GCN): A code assigned to a generic drug category.

Generic Sequence Number (GSN): Same as **Generic Code Number**.

Generate: To create or cause to be created.

GeoAccess: A third party vendor that processes and compiles provider data for the IPND.

Geographic Information System (GIS): A system of computer software, hardware and data used to manipulate, analyze and present information that is tied to a spatial location. Example: DSHS uses location data on providers and clients to analyze the relationship between the two, assess access and provide provider look up services by county, zip code, etc.

Graphic User Interface (GUI): A user interface to a computer system based on graphics (pictures and menus) rather than text. It uses a mouse as well as a keyboard as an input device.

H

Hardcopy: Paper rather than electronic representations of forms and information.

Health and Rehabilitation Services Administration (HRSA): The DSHS Administration that oversees alcohol and substance abuse services, Deaf and hard of hearing services, mental health services, the Special Commitment Center, and vocational rehabilitation services in the State of Washington.

Health Care Authority (HCA): A State of Washington entity that provides health insurance coverage to state employees and sponsors a Basic Health Plan for private sector employees with low incomes.

Health Care Financing Administration (HCFA): The former name for the Center for Medicare & Medicaid Services (CMS), the federal agency legislatively charged with administering the Medicare, Medicaid, and Children's Health Insurance Programs.

Health Care Financing Administration Common Procedure Coding System (HCPCS): The standard code set for Procedure Codes, including CPT Codes and codes for other medical and medically related services. This code set is still called HCPCS in spite of the federal agency's name change.

Health Care Provider: (HC Provider) Any person or organization that furnishes, bills, or is paid for medical or health services, or health care in the normal course of business. There are two major categories of providers who perform the following typical functions:

1. Fee for Service Provider: typically inquire about eligibility; inquire about benefits/specific benefits; contract with health plans; provide services; bill; and inquire about claim status.
2. Capitated Provider: typically inquire about eligibility; inquire about benefits/specific benefits; contract with health plans; provide services; report encounter records; receive capitation for managed care plan; send capitation; and receive encounter records.

Health Plan Employer Data and Information Set (HEDIS): A set of federal report specifications created in the early nineties as part of President Clinton's health care initiative and originally intended for use by employers for comparing health plans available for their employees. HEDIS reports can also be used by Medicaid Agencies that contract with capitated health plans to compare service utilization by members of various plans.

Health Plan: An organization that maintains networks of medical providers and pays for medical services for enrolled clients in exchange for a prepaid monthly premium or capitation payment.

Healthy Options (HO): The DSHS Medicaid managed care program for low-income people in the State of Washington. Healthy Options offers eligible families, children under 19 including children in SCHIP, and pregnant women coverage for medical benefits.

Health Insurance Portablility and Accountability ACT (HIPAA): Federal legislation aimed at administrative simplification for the health care industry, including rules on Transaction and Code Sets, privacy, security, NPI, etc.

Health Insurance Premium Payment (HIPP): A state program that pays the employee component of health insurance premiums for low wage workers.

HealthWatch Technologies (HWT): A health care systems company that provides payment accuracy auditing, overpayment recovery, and other services supported by claim data to HRSA.

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Health Watch Technologies – Decision Support System (HWT- DSS): A data warehouse and decision support system with historical data from MMIS claims and SSPS invoices.

Health Level 7 (HL7): An international set of standard formats for passing health care data among computer systems. HL7 standards differ from the standards mandated by HIPAA Transactions and Code Sets in that they emphasize electronic messages about patients sent between providers rather than communications between providers and health care payers.

Home and Community Based Services (HCBS): A Medicaid waiver program that provides in-home and residential services for people who would otherwise be institutionalized.

Home and Community Based Waiver (HCBW): A directive issued by CMS that enables a State Medicaid Agency to sponsor non-institutional services for clients whose assessments would otherwise require institutional levels of care.

Health Professions Quality Assurance (HPQA): A Washington Department of Health Office that licenses medical providers and investigates complaints from members of the public. HPQA maintains a Provider Licensing File that DSHS accesses to validate provider information at the time of enrollment.

HWT Database: A data warehouse with historical data from MMIS claims and SSPS invoices.

I

Identifiers: Unique identifier used in the administration of health care to signify a single health care provider, health plan, employer, and individual (consumer); intended to simplify administrative processes, such as referrals and billing, improve accuracy of data and reduce costs.

Identify: Select as matching a set of criteria.

Immigration and Naturalization Service (INS): The federal agency responsible for immigration procedures.

Individual Taxpayer Identification Number (ITIN): An identifier assigned by SSA to individual taxpayers who are not eligible to receive a Social Security number.

Inclusive Case Management System (ICMS): A system used by the Economic Services Administration (ESA) of DSHS to maintain General Assistance client information.

Infant Toddler Early Intervention Program (ITEIP): An ADSA early intervention program that provides services to children that schools recognize as developmentally disabled.

Information Services Board (ISB): A 15-member Board comprised of leadership from the Legislature, state agencies, higher education and the private sector. State law directs the ISB to: develop standards governing the acquisition and disposition of equipment, software and purchased services; approve Information Technology (IT) acquisitions or set rules that delegate acquisition authority; develop statewide or

interagency technical policies; review and approve the statewide IT strategic plans; provide oversight on large projects; establish and monitor appeals processes.

Information Services Division (ISD): The Division within HRSA that provides information systems development services and oversight of operations for the MMIS and other information systems that support the Medical Assistance Administration.

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Information System Services Division (ISSD): The entity within the Office of the Secretary that develops and administers IT standards and policies applicable to DSHS, manages the e-center and IT Portfolio program.

Input: Data coming into a computer system by means of data entry, electronic transactions, or interface files. Contrast with **Output**.

Integrated Case Management System (ICMS): A system used by the Mental Health Division of DSHS to maintain information on clients.

Integrated Provider Network Database (IPND): A database that maintains information on providers in health plan networks including plans sponsored by HRSA and HCA. It is the basis for managed care provider data available from the DSHS Web Site.

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Integrated Test Facility (ITF): A suite of modern software designed to establish an isolated environment for testing computer applications. Separate test regions for unit, system, and user acceptance test data as well as appropriate copies of the logic modules that make up the system are established. Version control procedures and update schedules are used to facilitate tests, track bugs and facilitate regression test analysis.

Integration: Combining, associating, or bringing together. An integrated system is one in which all components operate consistently and in close association with one another.

Interactive Terminal Input System (ITIS): A client eligibility system formerly maintained by DSHS. ITIS data was converted to ACES in 1996.

Interactive Voice Response System (IVRS or IVR): An automated telecommunications system that provides callers with recorded instructions that enable them to request information and gives responses in English or another language.

Interfaces: Electronic files that are transferred from one computer system to another.

Interim Bill: An inpatient hospital claim that covers a partial rather than a complete stay.

International Classification of Diseases (ICD): The basic code set for medical diagnoses.

Internet: The worldwide network of computer networks that uses teleprocessing protocols to facilitate data transmission and exchange. The Internet is used throughout DSHS as a two-way information source.

InterQUAL: A set of automated decision support tools marketed by the McKesson Corporation.

Invoice Control Number (ICN): A number that identifies a claim including all of the service lines within it.

Involuntary Treatment Act (ITA): State of Washington legislation that permits involuntary commitment if, in the judgment of a county designated mental health professional, a person presents a danger to self, others, or property and/or the person is unable to provide for basic needs of safety and health.

J

J-Codes: HCPCS Procedure Codes for drugs dispensed by a physician rather than a pharmacist. The initial character of these codes is always "J".

Joint Application Development (JAD): A method of eliciting system requirements that features structured group processes and extensive documentation.

Juvenile Rehabilitation Administration (JRA): One of the six Administrations of DSHS. JRA provides preventative, rehabilitative, residential, and transitional programs for juvenile offenders.

K

KOVIS: A document scanning and retrieval system used by HRSA to store Medicaid provider contracts.

Deleted: MAA

L

Labor and Industries (L&I): The State of Washington Worker's Compensation Agency. It provides cash and medical benefits to eligible persons who are injured while working and interfaces with DSHS for provider employee information.

Length of Stay (LOS): The number of days that a person is in a hospital or residential facility.

Limited Liability Corporation (LLC): A type of business organization registered with the Washington Secretary of State.

Local Procedure Codes: Level 3 HCPCS Procedure Codes established by health care payers and formerly accepted by HRSA on claims, especially claims for medical equipment and supplies. Local codes have been replaced by national HCPCS codes on HIPAA compliant claim transactions but are still used internally for claim adjudication within the current MMIS.

Deleted: MAA

Lock-in: A program that restricts selected Medicaid clients to services from particular physicians and/or pharmacists.

Long-Term Care (LTC): A nursing facility in which people who are incapacitated because of age or disabilities reside.

M

Maintain: Create, change, update, delete or keep in optimal status.

Maintenance and Operations: Services provided by the Vendor post DDI, including but not limited to system enhancements and upgrades, data center operations and staffing, and Pharmacy Clinical Services (see RFP Sections 2.8 and 4.8.2).

Manage: To direct or carry on business.

Management and Administrative Reporting Subsystem (MARS): A federally mandated MMIS subsystem that produces financial and utilization reports.

Management Services Administration (MSA): One of the seven Administrations' of DSHS. MSA provides centralized services and support to the public, vendors, Department staff, and facilities.

Mandatory Requirement (MR): The specifications within each section or subsection of this RFP which are marked (MR) in the title, including all referenced appendices and documentation, are Mandatory Requirements of this RFP, which will be scored as Pass/Fail. A Bidder's proposed solution must meet all mandatory requirements. Failure, in the Transmittal Letter, to indicate Bidder's agreement with all MR sections may result in disqualification of the Bidder's proposal.

MAPPER: A client tracking system formerly used by JRA and replaced by CATS.

Maximum Allowable Cost (MAC): An amount on First Databank's Drug File that can be used in pharmacy claim pricing.

Medicaid: The medical assistance program described in Title XIX of the federal Social Security Act. Each state administers a separate Medicaid Program that is financed by both federal matching funds and state funds and is subject to federal review.

Medicaid Eligibility Verification System (MEVS): An interactive electronic system that medical providers use to verify eligibility for Medicaid clients.

Medicaid Managed Care (MCO): The Medicaid program that administers contracts with health plans to provide services to Medicaid eligible clients on a per-member per-month premium payment basis.

Medicaid Management Information System (MMIS): The federally approved system used by the Washington Medicaid program to pay provider claims for goods and services authorized under the State Plan. The MMIS is certified by CMS and is the primary information system used by DSHS to pay for health care.

Medicaid Statistical Information System (MSIS): The system that produces the State MSIS Report that provides summary data on Medicaid eligibles, recipients, and services, and on medical provider payments. Since 1972, all states and territories that operate Medicaid programs are required to report annually. The MSIS Report has 14 sections that contain aggregate data broken down by service types and demographic categories.

Medical Assistance Administration (HRSA): One of the six administrations of DSHS. HRSA provides health care coverage to low-income families.

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Medical Eligibility Determination Services (MEDS): A statewide CSO that determines children's eligibility in an expedited manner for applicants applying for Medicaid.

Medicaid Information Technology Architecture Initiative (MITA): A federal initiative to modernize the technology and architecture of Medicaid Management Information Systems (MMIS).

Medical Personal Care (MPC): A Medicaid program that provides personal care and essential household tasks for clients living in their own home or in a community residential setting.

Medically Necessary: A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting

the service. "Course of treatment" may include mere observation or, where appropriate, no treatment at all.

Medicare: A federally sponsored health insurance program for people over 65 years old.

Medicare Carrier: A private company that contracts with Medicare to pay claims for Medicare beneficiaries.

Medicare Intermediary: A private company that contracts with Medicare to pay Medicare Part A claims for Medicare beneficiaries.

Medicare Enrollment Database (EDB): A national database of Medicare beneficiaries maintained by CMS.

Medicare Physician Fee Schedule Database (MPFSDB): A Medicare Data Base that is used by HRSA as a basis for physician's payments.

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Membership Billing Maintenance System (MBMS): A system operated by the Health Care Authority and accessed by MEDS for information on changes in eligibility.

Mental Health Division (MHD): A division within the DSHS Health & Rehabilitative Services Administration that is concerned with mental health services.

Modify: To make basic or fundamental changes

Modern MMIS: The future MMIS as opposed to the current MMIS.

N

National Association of Boards of Pharmacy (NAPB): A national organization of state Boards of Pharmacy. State Boards of Pharmacy license pharmacists and support the interests of the pharmacy community.

National Association of Insurance Commissioners (NAIC): An organization of State Insurance Commissions that provides standards and guidelines for the insurance industry.

National Council for Prescription Drug Programs (NCPDP): An organization that maintains standard NDC Drug Codes and a standard, HIPAA compliant format for pharmacy claims.

National Drug Code (NDC): The standard code set for drugs obtained from pharmacies.

National Provider Identifier (NPI): A HIPAA rule to provide a national standard health care provider identifier to aid in administrative simplification.

National Uniform Billing Committee (NUBC): An organization that develops and maintains paper and HIPAA compliant electronic standards for institutional claims.

Navigation: In an on-line computer system, the process of going from one computer screen to another.

NIST: National Institute of Standards and Technology.

Nursing Facility (NF): Same as **Long-Term Care Facility**.

Nursing Home (NH): Same as **Long-Term Care Facility**.

O

Office of Financial Management (OFM): The state agency responsible for providing accounting policy and the maintenance of the Agency Financial Reporting System (AFRS).

Office of Financial Recovery (OFR): An office within the DSHS Financial Services Administration (FSA) that is responsible for collection of debts owed from providers and clients to the Department, including financial, medical, and food stamp overpayments and Department liens.

Office of Accounting Services (OAS): An office within the DSHS Financial Services Administration (FSA) that is responsible for the agency's cost allocation plan, chart of accounts, federal draws, cash receipting, payroll and CMS 64 preparation. This office also handles the distribution of the weekly warrants and remittance advices issued to the Medicaid Providers.

Office of the Attorney General (OAG): The state entity responsible for criminal prosecution, including prosecution of fraudulent providers and clients.

Office of the State Treasurer: The state entity responsible for cash management activities related to processing of all Medicaid payment warrant files and EFT transactions to Medicaid providers.

OmniTrack: A computer system used by some HRSA sections to track client contacts and by other sections to track provider contacts. It is a Sybase system operated by ACS.

Deleted: MAA

On-line Processing: A mode of computer processing in which responses are immediate and interactive. Contrast with **Batch Processing**.

Optical Character Reader (OCR): An electronic device that reads handwritten characters created in a standard format and converts them to electronic data.

Outpatient Prospective Payment System (OPPS): A rule issued by CMS that specifies approximately 400 Ambulatory Payment Classifications (APCs) with relative

weights and base payment rates for use in pricing medical and surgical services. APCs serve a role similar to that of DRGs for inpatient services.

Output: Data going from a computer system in the form or a file, electronic transaction, or report. Contrast with **Input**.

P

Patient Participation: The amount of individual financial assets that a client must spend down before the Medicaid program will make payment towards the cost of a medical service. Some states refer to this as a Cost Share.

Patient Requiring Regulation (PRR): A client in a lock-in program who is restricted to authorized providers.

Pay and Chase: A method of COB in which a payer pays claims that may have third party coverage and attempts to recover all or part of the payment amount from another insurance carrier. Contrast with **Cost Avoidance**.

Payment: In claims processing, the system component that generates checks or electronic transactions to transfer money to providers, health plans, and other external entities. Contrast with **Pricing**.

Payment Error Reduction and Measurement (PERM): A program that attempts to identify common claim errors by sampling and reviewing data from Claim History so that error rates can be reduced.

Payment Review Program (PRP): A State of Washington Program that performs post-payment review to identify claim errors that resulted in overpayments to providers and initiates recoveries.

Performing Provider Number: The provider identifier associated with the provider who renders care.

Personal Digital Assistant (PDA): A small, hand-held electronic device used to store information such as phone numbers and schedules.

Personal Identification Code (PIC): An “intelligent” Client Identifier used in the current Washington MMIS. It includes Client Name, Date of Birth, and other data elements that provide unique identification of each individual client.

Pharmacy Benefit Manager (PBM): An entity that processes pharmacy claims. ACS serves as a PBM for DSHS.

Point of Sale (POS) Pharmacy Claim System: A companion system to the MMIS currently operated by ACS in its role as PBM that processes claims for pharmacy benefits.

Portable Document Format (PDF): A widely used format for documents available on the Internet.

Premium: A payment made to an insurance carrier in return for coverage. In an HRSA context, "premium" often refers to capitation payments made to health plans.

Price/Pricing: In claims processing, the determination of the amount that a provider should be paid for a particular covered service. Contrast with **Payment**.

Primary Care Case Management (PCCM): An arrangement by which a provider contracts with DSHS as a primary care case management (PCCM) provider to provide health care services to eligible HRSA clients under HRSA's Managed Care Program.

Primary Care Options Program (PCOP): An HRSA program that enables managed care clients to select primary care providers.

Primary Care Provider (PCP): An individual physician, Advanced Registered Nurse Practitioner (ARNP), or Physician Assistant (PA) who provides and coordinates medical care services.

Prime Vendor/Contractor: The primary entity that accepts full responsibility for the entire Scope of Work requested in this RFP.

Prior Authorization (PA): See Authorization (medical) and Authorization (social service).

Privacy and Security: A HIPAA component that mandates confidentiality of personal medical information and secure maintenance of health care data.

Procedure, Diagnosis, Drug, and DRG (PDDD) File: A basic Reference File in the current Washington MMIS.

Process: To execute a series of functions designed to achieve a specific result through to completion on a set of data in a computer system. Processes can involve comparison, arithmetic and logical operations, and decisions.

Produce: To make or cause to occur

Program of All-Inclusive Care for the Elderly (PACE): A Medicaid program that provides a comprehensive set of Medicare/Medicaid acute and long term care services in a home and community based setting on a pre-paid capitated basis in designated areas of the State.

Proposed Solution: The full functionality of the transfer system proposed by the Bidder in its response to this RFP.

Protected Population: Clients for whom a special level of confidentiality must be maintained due to their vulnerability or because of the requirements of federal or state legislation. Foster children, adopted children, abused women, JRA clients, and mental health clients are considered protected populations.

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Providers: Any individual or entity furnishing Medicaid goods or services under an agreement with the Medicaid agency.

Provider on Review: A provider of services contracted with DSHS who is subject to scrutiny because of suspected fraud, abuse, or inappropriate rendering of services.

Q

Qualified Medicare Beneficiary (QMB): A program under which DSHS pays for Medicare deductibles and co-payments, Medicare Part B premiums, and/or Medicare Part C (which covers HMO premiums and co-payments) for clients who are eligible for both Medicaid and Part A Medicare.

Quality Assessment Improvement and Monitoring (Q-AIM): A section within HRSA's Division of Medical Management that measures health care performance, conducts quality control and external quality review studies, monitors health care and service delivery systems, and is responsible for DMM contract development and execution.

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Quality Assurance (QA): A process of analysis and review that endeavors to reduce errors and maintain quality for software, data, or procedures.

Query: An electronic request for information from the data maintained by a computer system.

R

Ratio Cost to Charge (RCC): A pricing methodology based on the relationship between the cost of a service and the amount charged for it.

Real Time: Data sharing or processing data functions with immediate and interactive response times.

Reconciliation: The process of comparing separate versions of the same data to ensure that both versions are identical. Client eligibility in MMIS, for example, could be reconciled with eligibility in ACES.

Regional Support Network (RSN): An entity that covers a county or a group of counties that is certified by the Mental Health Division (MHD) of DSHS to administer community mental health programs at a local level. Each RSN contracts with facilities and outpatient providers and distributes block grant funds for authorized mental health services.

Remittance Advice (RA): A paper document or electronic transaction that tells a provider how claims have been adjudicated. RAs are normally issued in association with claim payments.

Request for Proposal (RFP): A document issued by a government agency that solicits proposals for work by external entities. RFPs frequently involve development and/or maintenance of computer systems.

Residential Care Services (RCS): A division of ADSA that sets rules for and inspects residential care facilities.

Resource Based Relative Value Scale (RBRVS): A method of paying physicians for services that places a value on each procedure based on the duration, complexity, skill, and training required to perform the service. HRSA multiplies RBRVS values by a statewide factor to determine physician payment rates.

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Retain: To keep for a period of time.

Retention Duration: The length of time that a particular kind of data (for example, rate date) is maintained in a computer system.

Return on Investment (ROI): The amount of income or cost savings expected from an expenditure.

Revenue Code: A code set used on institutional claims and encounters to identity particular kinds of service.

RFP Coordinator: The single point of contact for those Bidders who are interested in responding to this RFP.

Room and Board (R&B): The lodging and food services provided by a residential facility such as a hospice.

Rural Health Center (RHC): A clinic established by the 1977 Rural Health Clinic Act to stabilize access to outpatient primary care in underserved rural areas and encourage the use of physicians, physician assistants, nurse practitioners, and certified nurse midwives (CNMs).

S

S-Codes: Temporary national HCPCS Procedure Codes developed by Blue Cross/Blue Shield and other commercial payers.

Scored Requirement (SR): The section or subsections of this RFP, which are marked (SR) in the title. These requirements will be scored in accordance with Section 7, Evaluation and Selection.

Service Limit: A limitation placed by a health care payer on the extent or frequency of a medical service for which it will pay a provider.

Set (Noun): A group of one or more similar entities. (Verb): To apply a pre-determined value or attribute.

Social Security Administration (SSA): The federal agency that administers Social Security and SSI Programs.

Social Security Number (SSN): Identifiers assigned by SSA to employees and employment seekers. SSNs are used primarily to track Social Security contributions and benefits but are also widely used as individual identifiers for other purposes.

Social Service Payment System (SSPS): An automated system used by DSHS to authorize and pay for social services.

Social Service Provider: Any person or organization that furnishes, bills, or is paid for social services in the normal course of business.

Software: The object code version of computer programs and any related documentation that enables the operation of the MMIS, excluding maintenance diagnostics. Software must also mean the source code version, where provided by the contractor.

Special Low-Income Medicare Beneficiary (SLMB): A Medicaid Program for clients who have applied for or are enrolled in Medicare Part A. Client income limits are over 100 percent but under 120 percent of the Federal Poverty Level. Under SLMB, DSHS pays only the client's Medicare Part B premium.

Specifications: All technical and functional requirements, legal and regulatory requirements, performance standards, and any other objective criteria that need to be met to confirm correct performance.

SSI-eligible clients: Persons who receive federal cash benefits under the SSA's Supplemental Security Income (SSI) Program and who automatically receive Categorically Needy (CN) medical coverage. The federal Social Security Administration (SSA) administers the SSI program. The SSI income standard is the Federal Benefit Rate (FBR).

State Administrated Child Welfare Information System (SACWIS): A case management, payment, and reporting system for foster parents, adoptive parents, and institutions that serve Child Welfare clients.

State Children's Health Insurance Program (SCHIP): Same as the Children's Health Insurance Program (CHIP).

State Maximum Allowable Cost (SMAC): A method of drug pricing that began in 1972 to help control the cost of the pharmacy program. The SMAC process identifies multi-source drugs (e.g., generic drugs) that have actual acquisition costs below established reimbursement rates to providers and adjusts reimbursement rates to make them closer to the actual acquisition costs.

State Medicaid Manual: Part 11 of the CMS manual governing Medicaid Management Information Systems, including MMIS approval procedures and system requirements.
The CMS link to the State Medical Manual, Part 11 is:

http://www.cms.hhs.gov/manuals/45_smm/sm_11_11_toc.asp

State Plan: The comprehensive written commitment by a Medicaid agency, submitted under 1902(a) of the Social Security Act and approved by CMS, to administer or supervise administration of a Medicaid program in accordance with Federal and state requirements.

Subcontractor: One not in the employment of the contractor, who is performing all or part of the services awarded by the contract resulting from this RFP, where said individual has a separate contract with the Contractor. The term "Subcontractor(s)" means Subcontractor(s) in any tier.

Subset: To create set of elements from a given set.

Superior Court Management Information System (SCOMIS): A case management system used by Washington Superior Courts.

Supplemental Security Income (SSI): A federal program administered by SSA for severely disabled clients. HRSA's FFS medical assistance program covers SSI clients.

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Support: To perform an action that assists in the performance of another action, as in "support claim processing".

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Surveillance and Utilization Review (SUR): A unit within HRSA that performs post-payment review to detect fraud, abuse, and inappropriate utilization or provision of services.

Surveillance and Utilization Review Subsystem (SURS): A required MMIS subsystem that performs statistical analysis of claim data to identify providers and clients whose service and utilization patterns deviate from norms.

System: The complete collection of the Software, Systems Software, processes, data and equipment as described in the successful Vendor's proposal, integrated and functioning together, in accordance with the applicable requirements and specifications.

System Software: Operating system software, software utilities, project software development tools, database management software, programming languages, and other third party software (except for the Application Software) that the successful Vendor will license to DSHS in machine readable format for use with the equipment and software. Enhancements to the Systems Software.

T

Telecommunications Device for the Deaf (TDD): An electronic device that converts telephone voice messages to written words that deaf people can read.

Temporary Assistance for Needy Families (TANF): A temporary welfare program called Work First in Washington. It was created by Welfare Reform legislation as a replacement for the Aid to Families with Dependent Children (AFDC) Program and gives aid to children and to the adults who care for them.

Therapeutic Consultation Service (TCS): An automated point-of-sale alert that facilitates appropriate and cost-effective use of prescription drugs.

Third Party Liability (TPL): Same as **Coordination of Benefits (COB)**.

Time: All references to time refer to the local time in Olympia, Washington.

Timing: The time frame in which a data processing activity is accomplished; on-line or batch.

Title XIX: The portion of the federal Social Security Act that covers Medicaid.

Title XXI: The portion of the federal Social Security Act that covers the Children's Health Insurance Program (CHIP).

Track: Maintain the identity and status of an entity as it is processed repeatedly by an automated or manual system.

Transaction Control Number (TCN): A unique field value that identifies a claim transaction assigned by Washington's MMIS.

Transactions and Code Sets (TCS): A HIPAA component that mandates formats for electronic transactions related to health care payment and specifies sets of data element values that are valid on transactions.

Transfer System: The MMIS that the Bidder proposed to transfer from another state to Washington.

Transportation Brokers: Entities with which HRSA contracts to arrange medical transportation services to Medicaid clients. Brokers screen client requests for eligibility and arrange the most appropriate and least costly method of transportation for clients, including public buses, gas vouchers, client and volunteer mileage reimbursements, nonprofit providers, taxies, "cabulances", and commercial buses and airlines.

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Transportation and Interpreter Services Section (TISS): An HRSA Section that provides transportation and interpreter services to HRSA clients. Transportation services are arranged through transportation brokers.

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Treatment and Assessment Report Generation Tool (TARGET): A system maintained by the DSHS Division of Alcohol and Substance Abuse (DASA) that maintains chemical dependency residential treatment data.

U

United States Post Office (USPS): An entity that, in addition to delivering mail, establishes standards for address components.

Universal Billing (UB): The basic claim form used for institutional services.

Universal Provider Identification Number (UPIN): The number used by Medicare to identify providers.

Update: To add, change, or delete the value of a field or set of fields.

V

Value: (Verb) To establishing a claim's payment amounts by using all appropriate methods of pricing.

Vendor: The firm or entity performing services under a contract awarded under this RFP, including all employees of the Vendor.

W

W-2: The tax form that DSHS sends to individual employees and to the IRS. It shows FICA, FUDA, and other deductions from employee payments.

Washington Administrative Code (WAC): A set of rules governing the administration of federal and state laws and court decisions. Many DSHS policies and decisions reference particular WACs.

Washington Medical Integration Project (WMIP): A DSHS program developed to examine the potential benefits of providing services in a more integrated fashion to aged and disabled clients who receive medical care, mental health treatment, and long-term care services.

Women, Infants & Children Program (WIC): A supplemental nutrition program for women, infants and children.

Worker's Compensation: Insurance that employers are required to have to cover employees who become sick or injured on the job.

Working/Business Days: Monday through Friday, except for legal holidays observed by the State of Washington.

Working Connections Automated Program (WCAP): A client registry and case management system used by the WCCC Program.

Working Connections Child Care (WCCC): A DSHS program that helps families with children pay for child care to find jobs, keep their jobs, and get better jobs.